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Mental Health and Offending in Older People: Future Directions for Research

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Abstract:

Background: The number of older people and their proportion of the prison population in high-income countries has increased dramatically in recent years. This pattern is mirrored by the age profile in forensic hospital services and both trends seem counter to the age-crime curve concept. How do we understand this and what are the mental health needs of this growing group?

Aim: To identify existing research robust enough to inform policy and practice in relation to mental health in older offenders and the knowledge gaps which should drive future research.

Methods: A keyword based search strategy of the databases Embase, PsychINFO, Medline and grey literature 2008-2018. Article selection was limited to empirical research with the potential to inform policy or practice and findings synthesised narratively.

Results: Much of the research in this field focuses on prevalence and the increased psychiatric morbidity of the older offender population. Older prisoners and those older

patients in secure hospitals have needs which differ in some respects from their younger counterparts and community dwelling older people. There are few studies of interventions for mental health in older prisoners or into the challenges of timely release given their complex needs. Discharge of older individuals from secure settings is also an area where further research is required in order to inform policy and service provision.

Conclusions: The older population in prisons and secure settings is growing and there is much concern as to how far facilities and services have been able to identify and meet the mental health needs of those of older age. Co-operation between researchers and services and between disciplines will be essential if we are to secure a more robust evidence base in this respect. Engaging service users in such research and considering the whole criminal justice pathway including diversion remains a priority.

Introduction

There has been an awareness of the increased psychiatric morbidity of the older offender population for many years (Taylor and Parrott, 1988; Fazel et al., 2001a) but with populations ageing worldwide recent interest has focussed on the challenges this poses for health, social care and criminal justice. The unprecedented rise in the age profile of the global prison population has been associated with both the ageing of the general population and the use of longer sentences which has increased the numbers of people growing old in prison (Psick et al., 2017).

Previous studies on older people in contact with the Criminal Justice System have used a range of age thresholds (ranging from 50 to 65 years). The majority of studies in this area now

define people aged 50 or more as 'older' on the basis that there is around a 10 year differential between the overall health of prisoners and that of the general population .Many face multiple chronic conditions which include both medical conditions and multiple functional impairments (Williams et al., 2012; Greene et al., 2018). Adverse health risks across the lifespan such as homelessness, limited access to healthcare and trauma are likely to be contributory factors. The lower life expectancy of people with severe mental illness in England and Wales (Department of Health 2017) is also of note. This choice contrasts with the more positive trajectory of ageing supported by studies of community dwelling older people.

This is a narrative review which incorporates some elements of systematisation. Its aim was to explore the area and identify research and policy priorities. Recent literature in the area of mental health and offending in older people was reviewed using a keyword based search strategy with Embase, PsychINFO and Medline and the following keywords:

Older (or Elderly or Geriatric or Aged or Aging)
AND (Mental health)
AND (Forensic or Secure or Services or Offending or Offences)
AND (Prisons or Prisoners)

The search was limited to English language research publications and grey literature going back ten years (2008-2018). Key articles related to the theme were identified and reference lists reviewed for any supplementary publications that matched the search strategy, key words and scope of the review. Several capable articles address clinical issues likely to be of relevance in the assessment of older mentally disordered offenders (Fazel, 2014; Natarajan & Mulvana, 2017; Yorston, 2018). This review focuses on research studies that can inform wider policy and practice in the area and future directions for research (N = 39). Articles

without empirical data, e.g. commentaries were excluded (N= 44). An additional 6 earlier references were selected as background information.

Prison Studies

The number and proportion of older people in prison is rising in high-income countries globally (US Dept. Justice, 2016; Trotter and Baidawi, 2015) and older prisoners form the fastest growing age demographic. As of 30th June 2018, prisoners aged 50 and over comprised 16% of the total prison population in England and Wales (Ministry of Justice, 2018). Al-Rousan, et al. (2017) reported that 17% of prisoners fell into this age range in Iowa in 2015. The number of prisoners in their 60s and 70s in England and Wales is projected to rise further over the next 5 years, mainly driven by the increase in late in life prosecutions for historic sex offences since 2012 and by changes in sentencing such that longer determinate sentences are being served by older prisoners. Growth is slightly offset by a decline in the indeterminate sentenced population (Ministry of Justice projections, 2018). In the U.S. the increase in older prisoners is attributed to the ageing of the general population, harsher sentencing and the elimination of parole programmes (Stoliker and Varanese, 2017).

Prevalence of Psychiatric Disorder in older prisoners.

In a study of 203 sentenced male prisoners aged 60 or over across 15 prisons in England and Wales (Fazel et al., 2001a) 30% of the group had a depressive illness and 30% personality disorder both of which were higher than rates described for younger prisoners. 1% of the sample received a diagnosis of dementia which was considered to reflect diversion of men with dementia at the point of arrest. A lifetime history of alcohol misuse was recorded for 23 prisoners. The prevalence of depressive illness was 5 times that of a similar community

sample and poor physical health was associated with a greater risk of depression. Of concern only 18% of men with psychiatric morbidity were treated with psychotropic medication (Fazel et al., 2004) although they were largely receiving appropriate medication for physical health conditions. A study of older remand prisoners in Ireland (Davoren et al., 2015) identified higher rates of affective disorder and alcohol misuse than in younger prisoners .

The finding that around 50% of older prisoners have a mental health condition has been replicated more recently in England and Wales (Kingston et al., 2011; Hayes et al., 2012; Senior et al. 2013), Australia (Trotter and Baidawi, 2015) and the U.S. (Al-Rousan et al., 2017). Senior et al (2013) again highlighted that while half of their participants were suffering from depression (31% mild, 23% severe) only 17% were treated with antidepressant medication and just 12% had early contact with a mental health nurse. Help with psychological stress was an area of unmet need. Kingston et al. (2011) similarly reported unmet need in that only 18% of those with mental disorder were prescribed medication from the appropriate class. O'Hara et al. (2016) found that more than half of a cohort of 100 older male prisoners in the UK had high levels of depressive symptoms on entry to prison and that there was a significant association between depressive symptomatology and an unmet physical health need. Neglect of chronic health conditions including mental health in a cohort of 327 older women prisoners in the U.S. was experienced as commonplace (Aday and Farney, 2014).

Dementia and cognitive impairment in prisoners is recognised as an area requiring further investigation. Kingston et al. (2011) reported that 12% of men aged 50 or more in an interview study of 120 UK prisoners had signs of cognitive impairment. In a study of 138 older prisoners (50 plus) in France (Combalbert et al., 2018) around a fifth of the prisoners had executive

function test scores suggestive of dementia and cognitive impairment was more common than in a comparable community group. Prisoners suffering from cognitive impairment did not necessarily seek help or consider their quality of life to be affected. Di Lorito et al. (2018) compared 9 studies of older prisoners with similar studies in the community and concluded that the prevalence for dementia in prison studies was in the region of 3.3% and similar to community prevalence but studies indicated that cognitive impairment was more widespread. A link with poor physical health has been highlighted by a study of 310 prisoners in the US (Ahalt et al., 2018) who found cognitive impairment to be associated with multiple emergency room visits, hospital admission and repeat arrests over a 6 month follow up period.

In a comprehensive review of studies on the mental health of prisoners across the age range Fazel et al. (2016) notes the paucity of intervention studies and the likely importance of physical health problems, depression and limitations of functional ability in older prisoners.

One of the recommendations of a review of 314 investigations (2013 – 15) by the Prisons and Probation Ombudsman for England and Wales (2017) was for older prisoners to have a personalised care plan with a co-ordinated approach across primary care and mental health.

Psycho-social aspects of Imprisonment

The longer sentences being served by the older prison population, prison location and possible estrangement from family and friends due to the nature of offending, might be expected to limit the social networks of older prisoners. The relatively poor provision for older prisoners in relation to opportunities for exercise, education and work further restrict the

social networks of older prisoners (Aday and Krabill, 2012; Mann, 2012). However, there is much variability as to how far older prisoners maintain and develop social relationships in custody. Mann (2012) identified a small number of older men who reported an improvement in their well being. She also reported that some older prisoners in the study to be making a positive contribution to prison life through acting as role models or mentors to other prisoners. A study of 173 older men and women in prisons in Victoria and New South Wales (Trotter and Baidawi, 2015) found that older prisoners tended to socialise with older peers. 77% of the group engaged in work and participants spoke of this being vital in enabling them to 'cope' with prison life. Around half of the group had had at least one visit in the previous 2 weeks and 80% had been in telephone contact with family or friends. Older women were even more likely to maintain outside contacts. Levels of psychological distress were significantly associated with self-reported measures of safety, prison victimisation, current employment and levels of exercise (Baidawi et al., 2016). Those aged 65 or over were more likely to describe social disconnection, to have functional impairments (such as deafness, mobility problems) and to experience victimisation. The authors concluded that strategies to enhance peer support, personal safety and physical activity would be likely to have a positive impact on levels of distress in older prisoners.

A study of 67 older prisoners in the US (Filinson, 2016) reported older prisoners to be less active than older adults in the community and identified a quarter of subjects who participated in none of work, exercise or prison programmes. This poorly engaged group typically felt there were no tangible benefits to participation and perceived barriers to participation to be insurmountable. In a thematic review of inspections the Prisons Inspectorate for England and Wales (2008) reported that older prisoners who no longer work

spend long hours in the residential areas where their cells are located. Mann (2012) also found that regimes typically made no allowance for age limitations with a lack of meaningful activity for those not involved in work.

Planning for the release of older prisoners has been identified as an area of unmet need. In a study in the North of England. Forsythe et al. (2015) found older prisoners experienced high levels of anxiety about placement in probation approved-premises but the health and social care needs for those placed in such facilities were better met. Release planning overall was considered inadequate representing a missed opportunity for health intervention. In Canada, Shantz and Frigon, 2009 described the community reintegration experiences of older women after long periods in prison and found that they experienced many difficulties linked with their age, health and gender. Working in Australia discontinuity in mental health contact was identified in over half of a cohort of 1853 first time offenders over the age of 45 who had previously been in contact with mental health services in the year prior to imprisonment (Sodhi-Berry, 2015). There have been several studies of transitional support models that benefit offender groups with mental health needs such as the critical time intervention (Shaw et al, 2017) and extending the use of such models to meet the complex needs of older prisoners on diversion or release would be of interest.

Studies based in Secure Forensic Mental Health Facilities

Older people may enter secure hospital services when offending relating to mental disorder emerges for the first time in old age. A number of earlier retrospective studies examining referrals and admissions to medium secure services in the U.K. (Coid et al., 2002; Tomor et al., 2005) show that only a small proportion of referrals and admissions are of older people.

However, an increasing number of patients admitted at a younger age remain in hospital for many years. A large study of long-stay patients across England and Wales (Duke et al., 2017) in both high and medium secure hospitals found that about a third of the long stay population were aged 50 or over. Long-stay was defined as more than 10 years in high security, more than 5 years in medium security or more than 15 years across the two. The authors drew attention to the implications for service planning for these older long-stayers and given the variation between medium secure settings advised the need to further identify the needs of the long stay group and suitable therapeutic interventions. In a study of the wellbeing and security needs of 521 patients in secure services (Girardi et al., 2018) younger patients improved on most measures of the HoNOS-secure assessment whereas older patients showed little or no improvement on these scales.

Whether or not there is a need for older age specific forensic services has been a topic of debate in the U.K. with many authors suggesting that the needs of older service users are difficult to meet in generic secure services (Tomor et al., 2005; Natarajan & Mulvana, 2017). Now that around 25% of inpatients in a typical local low and medium secure forensic service in the U.K are aged 50 or over this advice is more likely to be of relevance to older people with complex needs including cognitive impairment.

Little is known about the perspective of the older service user on life and ageing in a secure forensic setting, what they consider their needs and whether these needs are being met. Yorston & Taylor (2009) conducted a qualitative study of the experience of 16 patients aged 60 or over in one English high secure hospital and concluded that care needs were variable and could not be assumed on the basis of age, requiring individual assessment. However

moving to a hospital with a lower level of security was an important topic for all patients. Di Lorito et al. (2018) in a qualitative study across high, medium and low secure settings in England has highlighted the complexity of the experience of ageing with positive feedback reported on themes relating to physical health care, education, spiritual and staff support but also barriers to recovery relating to social isolation and activities or treatment programmes that did not respond to their needs. In a further qualitative study Visser et al (2019) found that older adults accommodated in low and medium secure wards where there were others of similar age reported more social integration than those on wards dominated by younger adults. Most participants were reluctant to identify as “old” or “vulnerable”. Transitions from secure services to other placements were identified as particularly difficult and a culture of sensitivity and respect for older persons’ agency was considered key to collaboratively meeting additional care needs.

Community and Population based Studies.

There are limited findings on mental disorder and offending in older age outwith prison and secure hospital studies. Putkonen et al. (2010) conducted a register based study on homicide offenders aged 60 and over in Finland between 1995 and 2014 which reported that the older men and women were more often diagnosed with dementia and physical illness and less often with drug dependency and personality disorder. A study using national survey data in the U.S. (Bryson et al, 2017) found that mental health and substance misuse were much more usual in older adults on parole or probation than in the non- correctional group.

The Criminal Justice System in the U.K. has emphasised diversion of older people who offend for the first time in old age. Needham-Bennett et al. (1996) investigated the associations of

offending in 50 people of 60 and over detained in police custody using a formal assessment tool. 28% of the cohort had a diagnosable mental disorder including 4 people with possible dementia. The majority had been detained for shoplifting with 6% arrested for a violent offence and 5% for a sexual offence. In France, Beaufrère and Chariot (2015) investigated 211 people over 60 referred for medical examination in Paris in 2012. The older group were more likely to have physical and mental health disorders than younger detainees. 40% of the older group were arrested for physical assault.

A recent study (McKinnon et al., 2017) described the health of 56 people aged 50 and over at 3 police stations in the UK and compared the findings with a younger group. 5 of the older detainees were considered to have possible organic impairment which was likely to be associated with the incident for which they had been arrested but there was no significant difference between the older and younger groups in relation to serious mental illness, drug use or past contact with services. Older detainees had significantly higher rates of physical illness and risk of alcohol withdrawal. The authors recommended that older people who have been arrested should be routinely referred for health assessment.

FUTURE RESEARCH.

The most pressing policy challenge in relation to older mentally disordered offenders across high income countries concerns the dramatic rise in the older prisoner population over the last 5 years. Prisons experience considerable difficulties in meeting the needs of older prisoners. There is minimal modification of environment and regime to better support good physical and mental health, apart from the few prisons with specialist older adult units. There is a need for more research on how best to modify the environment to provide safe and social

surroundings for older prisoners and minimise the disruption of family ties. Developing areas of good practice with older prisoners into more uniform quality improvement across establishments would be valuable applied research.

How best to address the mental health needs and the quality of life of older prisoners continues to be an important area for research. The nature of social networks, physical health needs and the deprivations of the prison environment and how these interact with the increased prevalence of depression in older prisoners has been identified as an important area for further work. This should include health and social care interventions and develop our understanding of how to address the variable engagement of older prisoners. Work on victimisation and violence in relation to mental health is also important.

Another area likely to become increasingly significant given current trends is that of mild cognitive impairment and dementia. Developing an evidence base in relation to prevalence and exploring the care pathways and care planning that meet the needs of such prisoners is a priority along with training in this area for prison based staff. Research in this area should include investigation into the manner in which compassionate release can be facilitated for those prisoners who lack the capacity to engage in core aspects of the prison regime and the barriers to being able to implement appropriate and ethical care. Research on how far existing policy directives on diversion away from custody and the use of mental health treatment requirements in sentencing has been limited in relation to older people and merits further work focussing on barriers to more uniform implementation.

Research around secure hospital services has been sparse in relation to defining the needs of older people within such services and how far user views play a role in decision making about

their care and their quality of life. Greater clarity around choices with regard to age specific services would be useful as well as developing a better knowledge of different care pathways. An understanding of the barriers to transition from secure services to other care settings for older people and the nature of reintegration with the community following an episode of care in secure services would have immediate relevance to clinical practice. Despite the larger numbers of men in both prison and secure hospital populations it is still important to include the needs of women and other minority groups in future research. This review also indicates that routine inclusion of imprisoned older people in community studies around large scale interventions for mental health does not appear to occur and further opportunities to advance the knowledge base might be secured if programmes explicitly highlighted working across institutional barriers in research initiatives.

Clearly research in this area must extend beyond health and social care as many of the issues for older people in the criminal justice system relate to mental health within a wider policy and societal context. Inter-disciplinary research in relation to sentencing, parole and health related early release would be timely. The responsibilities of prisons to be health promoting institutions and the interventions most likely to mitigate the impact of what has been described by Mann, (2012) as 'doing harder time' should be an early focus of further work.

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